MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS

# LETTER OF INTENT FOR OPT's and/or CORF's

**COMPLETE INFORMATION AND RETURN ALONG WITH POLICY MANUAL AND MEDICARE FORMS, IF APPLICABLE. MAIL TO: MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES, BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS, P.O. BOX 570, JEFFERSON CITY, MO 65102.**

| NAME OF AGENCY | TELEPHONE NO. |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP) | COUNTY |
| CONTACT PERSON | Administrator's E-mail Address |

**TYPE OF AGENCY**

☐ OUTPATIENT PHYSICAL THERAPY CLINIC ☐ COMPREHENSIVE OUTPATIENT REHABILITATIVE FACILITY

**OWNERSHIP AND MANAGEMENT**

☐ Hospital Based
☐ SNF/ICF Based Agency
☐ Free Standing Agency
☐ Other
_____
_____
_____
_____

Provider Base Entity:
_____
_____
Address: _____
_____
_____
Provider Number: _____
Fiscal Year Ending Date: _____

***Non-Profit***
☐ Corporation
☐ Other (Explain)
_____

***Proprietary***
☐ Individual
☐ Partnership
☐ Corporation
_____

***Government***
☐ State
☐ County
☐ City
☐ City-County
☐ District

**EXTENSION LOCATIONS:**

LIST ADDRESSES, PHONE NUMBERS AND SITE COORDINATORS (ATTACHED ADDITIONAL SHEET IF NECESSARY)

**SERVICES PROVIDED** (Check all that apply)

☐ Speech Therapy ☐ Occupational Therapy ☐ Psychologist ☐ Other
☐ Physical Therapy ☐ Medical Social Services ☐ Rehabilitation Counselor _____

**FOR OFFICE USE ONLY**

**Initial Forms Received**

☐ 2572 ☐ 359 ☐ 1856 ☐ 855 Apprd:_____
☐ 1561 ☐ 690 ☐ 1513 ☐ SOS Registration

☐ FI Additional Info_____
☐ FI Additional Info_____
☐ FI Additional Info_____

Assigned Surveyor _____ Policy Manual Received _____ Surveyor Checked Out Manual _____

Forms Sent to RO: _____

Permission Given to Agency to Start Caseload: _____ Confirmation Letter (90): _____

Dates of Additional Contact: _____

_____

_____

_____

_____

Applicant Called Bureau - Ready For Survey: _____ Initial Survey Date: _____